

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

479

Village or City

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

White

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Single

6 DATE OF BIRTH

July

10

1906

(Month)

(Day)

(Year)

7 AGE

7

yrs.

6

mos.

15

ds.

If LESS than
1 day,.....hrs.
OR.....min.?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)9 BIRTHPLACE
(State or country)

Washington, D.C.

PARENTS

10 NAME OF
FATHER

Thomas E. Boorman

11 BIRTHPLACE
OF FATHER
(State or country)

Md.

12 MAIDEN NAME
OF MOTHER

Elizabeth Davis

13 BIRTHPLACE
OF MOTHER
(State or country)

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

191

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

104

St.; Ward)

[If death occurred in
a hospital or institution,
give its NAME instead
of street and number.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan

20

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Nov. 20

1913

to

Jan 20

1914

that I last saw him alive on Jan. 20, 1914

and that death occurred on the date stated above, at 10.15 A. M.

The CAUSE OF DEATH* was as follows:

Leukemia

(Duration) yrs. 2 mos. 9 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

L. O. Currier

M. D.

191 (Address) Piquette, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,
SUICIDAL, or HOMICIDAL.16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,
OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Mary's Church

Jan 27, 1914

20 UNDERTAKER

ADDRESS

Geo. L. Wood

Piquette

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

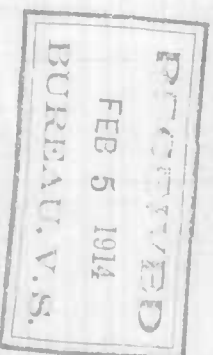
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative usefulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc. without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tremor," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as "fracture of skull, and consequences (e. g., *sepsis*, *tetanus*)" may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



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1 PLACE OF DEATH

480

County CharlesVillage or City White Plains (No. 120)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 1051

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME George Chace

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Caucasian 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH Unknown
(Month) (Day) (Year)

7 AGE 32 yrs. — mos. — ds. If LESS than 1 day, — hrs. OR — min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Hammer
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Charles County

10 NAME OF FATHER Edward Chace

11 BIRTHPLACE OF FATHER (State or country) Charles County

12 MAIDEN NAME OF MOTHER Eliza Howard

13 BIRTHPLACE OF MOTHER (State or country) Charles County

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edward Chace(Address) White Plains Md

15 Filed 1/29, 1914 J. M. Willerson
Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 28, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Spt, 1913, to Jan 28, 1914.

that I last saw him alive on Jan 27, 1914.

and that death occurred on the date stated above, at 220 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Bright Disease
(Duration) 2 yrs. — mos. — ds.

Contributory La Grippe
Secondary (Duration) yrs. — mos. — ds.

(Signed) J. O. Monroe, M. D.
Jan 29, 1914 (Address) Waldorf Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. — mos. — ds. In the State yrs. — mos. — ds.

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Unknown DATE OF BURIAL 1/30, 1914

20 UNDERTAKER Huitt & Ryan ADDRESS Waldorf Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—Homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County

Charles

481

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

102

Village or City

Shiloh, Maryland

(No.)

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Richard Ashton Cortee

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

Colored

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

25th May

(Month)

(Day)

1858 (Year)

7 AGE

54

yrs.

7

mos.

22

ds.

OR LESS than 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Farming

(b) General nature of industry, business, or establishment in which employed (or employer)

"

9 BIRTHPLACE

(State or country)

Charles County, Md

PARENTS

10 NAME OF FATHER

Samuel W. Cortee

11 BIRTHPLACE OF FATHER (State or country)

Charles County, Md

12 MAIDEN NAME OF MOTHER

Matilda Moore

13 BIRTHPLACE OF MOTHER (State or country)

Charles County, Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Johnnie Cortee

(Address)

Mayside Md

15

Filed

Jan 19, 1914 Henry M. Ward
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

1 - 17

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

May 1911, to Jan 17, 1914

that I last saw him alive on Dec 17, 1913

and that death occurred on the date stated above, at 3 p. m.

The CAUSE OF DEATH* was as follows:

British Incompetency

(Duration) 2 yrs. 8 mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

J. L. Anderson, M. D.

1 - 15 - 1914 (Address)

Mayside

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death yrs. mos. ds.

In the

State yrs. mos. ds.

Where was disease contracted,
It not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Shiloh County

Jan 19, 1914

20 UNDERTAKER

ADDRESS

Geo. H. Shade

Mayside Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Malaria* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
FEB 4 1914
BUREAU, U. S.

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1 PLACE OF DEATH

482

County

Charles

Village or City

Wayne St.

(No.)

St.; Ward)

Registration Dist. No.

104

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Still Born Deshields

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

Black

5 SINGLE,

MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Single

6 DATE OF BIRTH

January 6, 1914

7 AGE

1 day, 1 hr. 15 min.

8 OCCUPATION

(a) Trade, profession, or particular kind of work

None

(b) General nature of industry, business, or establishment in which employed (or employer)

None

9 BIRTHPLACE

(State or country)

Charles C. and

10 NAME OF FATHER

J. S. Deshields

11 BIRTHPLACE OF FATHER

(State or country)

Wisconsin and

12 MAIDEN NAME OF MOTHER

Georgia Colbert

13 BIRTHPLACE OF MOTHER

(State or country)

Charles C. and

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. S. Deshields

(Address)

Wayne St. and

15

Filed January 6, 1914, by H. M. Ward, Local Registrar

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

January 6, 1914

17

I HEREBY CERTIFY, That I attended deceased from

January 6, 1914, to January 6, 1914,

that I last saw him alive on January 6, 1914,

and that death occurred on the date stated above, at 3:50 A. M.

The CAUSE OF DEATH* was as follows:

Still Born

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) H. M. Ward, Local Registrar, M. D.

- 6 - 1914 (Address) Wayne St. and

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sheloh Cemetery, Charles C. and, 1914

20 UNDERTAKER

ADDRESS

Geo. St. Shade, Wayne St. and

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-theuia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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BUREAU, V. S.

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1 PLACE OF DEATH ⁴⁸³
 County Int Prospect Charles STATE OF MARYLAND
 Village or City Delabon (No. 7) Mayside St.; Ward) [It death occurred in a hospital or institution, give its NAME instead of street and number.]
 2 FULL NAME Willie R. Dyson Registration Dist. No. 104

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>female</u>	4 COLOR OR RACE <u>black</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)
6 DATE OF BIRTH <u>12-14-1844</u> (Month) (Day) (Year)		
7 AGE <u>70</u> yrs. <u>7</u> mos. <u>5</u> ds. <u>OR</u> <u>1</u> day, <u>1</u> hr. <u>1</u> min. ? If LESS than 1 day, hrs. min. ?		
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>house work</u> (b) General nature of industry, business, or establishment in which employed (or employer)		
9 BIRTHPLACE (State or country) <u>Charles Co</u>		
PARENTS	10 NAME OF FATHER <u>William Dyson</u>	
	11 BIRTHPLACE OF FATHER (State or country) <u>Charles Co</u>	
	12 MAIDEN NAME OF MOTHER <u>Amanda Lewis</u>	
	13 BIRTHPLACE OF MOTHER (State or country) <u>Charles Co</u>	

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. W. Dyson Brother
 (Address) Mayside Md

15 Filed Jan 17 1915 Henry M. Ward
Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 1-16-1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 27 1913 to Jan 16 1914.
 that I last saw him alive on Jan 8 1914.
 and that death occurred on the date stated above, at 8 p. m.
 The CAUSE OF DEATH* was as follows:
General Debility
No particular disease or condition
with no morbid condition
26 months (Duration) yrs. 20 mos. 5 ds.
 Contributory Secondary
 (Duration) yrs. mos. ds.
 (Signed) T. L. Higgins, M. D.
1-17-1914 (Address) Mayside

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
 Where was disease contracted, It not at place of death?
 Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Shelton CountyJan 18 1914

20 UNDERTAKER

ADDRESS

Geo. H. ShadeMayside Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

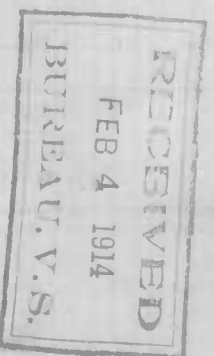
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Charles</u>		484		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Pisgah</u> (No. <u>170</u>)		St. <u>170</u> Ward		Registration Dist. No. <u>101</u>	
2 FULL NAME <u>Frederick Greer</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>married</u> (Write the word)			
6 DATE OF BIRTH <u>1837</u> (Month) (Day) (Year)					
7 AGE <u>77</u> yrs. <u>7</u> mos. <u>0</u> ds. OR <u>1</u> day, <u>0</u> hrs. <u>0</u> min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <u>Charles Co. Md.</u>					
PARENTS	10 NAME OF FATHER <u>Unknown</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>"</u>				
	12 MAIDEN NAME OF MOTHER <u>"</u>				
	13 BIRTHPLACE OF MOTHER (State or country) <u>"</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Naoma Greer</u> (Address) <u>Pisgah, Md. (93)</u>					
15 FILED <u>July 19</u> , 19 <u>14</u> <u>W. B. Thompson</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Jan 18</u> , 19 <u>14</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, that I attended deceased from <u>Nov</u> , 19 <u>13</u> , to <u>Dec</u> , 19 <u>13</u> , that I last saw him alive on <u>Dec</u> , <u>20</u> , 19 <u>13</u> , and that death occurred on the date stated above, at <u>3 A</u> m. The CAUSE OF DEATH* was as follows: <u>Senility</u> <u>hypertension</u> <u>Chronic</u> <u>HT</u> (Duration) <u> </u> yrs. <u> </u> mos. <u> </u> ds. Contributory <u> </u> Secondary <u> </u> (Duration) <u> </u> yrs. <u> </u> mos. <u> </u> ds. (Signed) <u>T. C. Bicknell</u> , M. D. <u>Jan 18</u> , 19 <u>14</u> (Address) <u>Pisgah Md.</u> *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u> </u> yrs. <u> </u> mos. <u> </u> ds. In the State <u> </u> yrs. <u> </u> mos. <u> </u> ds. Where was disease contracted, If not at place of death? Former or usual residence <u> </u>					
19 PLACE OF BURIAL OR REMOVAL <u>Smiths Chapel</u>				DATE OF BURIAL <u>July 20</u> , 19 <u>14</u>	
20 UNDERTAKER <u>W. B. Thompson</u>				ADDRESS <u>Wincoslar</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

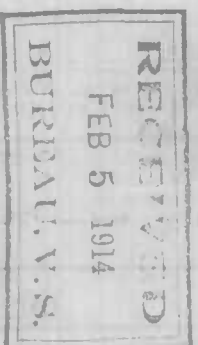
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

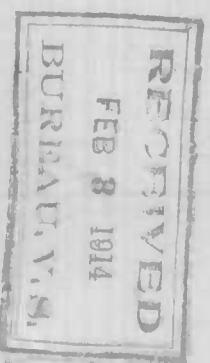
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' PLACE OF DEATH

486

County

Village or City

(No.

Registration Dist. No.

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

* FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

Colored

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Single

6 DATE OF BIRTH

Dec 8, 1914
(Month) (Day) (Year)

7 AGE

1 yrs. 29 mos. 29 ds.
If LESS than 1 day.....hrs.
OR.....min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

Infant

9 BIRTHPLACE
(State or country)

Md.

PARENTS

10 NAME OF FATHER

Albert Hawkins

11 BIRTHPLACE OF FATHER
(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Edelle Lyles

13 BIRTHPLACE OF MOTHER
(State or country)

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Informant

Carroll McPherson

(Address)

Bryantville

15

Filed

Jan 7, 1915 J. D. Chappell
Bryantville, Md. REGISTRARSTATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 6, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 31, 1913, to Jan 4, 1914.

that I last saw him alive on Jan 4, 1914.

and that death occurred on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

Contributory
(Secondary)

(Duration) yrs. 12 mos. 12 ds.

(Duration) yrs. 12 mos. 12 ds.

(Signed)

J. D. Chappell, M. D.
Jan 11, 1914 (Address) Bryantville

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. to the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St Mary's Church Jan 7, 1914

20 UNDERTAKER

ADDRESS

Albert Hawkins Bryantville, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

487

County CharlesVillage or City Bel Air (No. 90)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 103

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Annanda T. Jackson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Dark 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed
(Write the word)6 DATE OF BIRTH Sept. 18, 1845
(Month) (Day) (Year)7 AGE 69 yrs. 1 mos. 1 ds. If LESS than 1 day, hrs. 1 min. ?8 OCCUPATION
(a) Trade, profession, or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)9 BIRTHPLACE (State or country) Charles County10 NAME OF FATHER (not known) Shorser11 BIRTHPLACE OF FATHER (State or country) Not known12 MAIDEN NAME OF MOTHER Malinda Coffey13 BIRTHPLACE OF MOTHER (State or country) Ches. Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Annanda T. Jackson(Address) Bel Air15 Filed Jan. 13, 1914 Charles H. Roby
Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. 12, 1914
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1912, to Jan. 12, 1914.that I last saw her alive on August, 1913and that death occurred on the date stated above, at 1:15 P. m.

The CAUSE OF DEATH* was as follows:

Exhaustion(Duration) yrs. 10 mos. 10 ds.Contributory (Secondary) Chronic Bronchitis, & emphysemaHeart & Kidney (Duration) 7 yrs. 10 mos. 10 ds.(Signed) E. J. Jackson, M. D.Jan. 13, 1914. (Address) Bel Air

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. 10 mos. 10 ds. In the State yrs. 10 mos. 10 ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mount Rest Cemetery, Lohrstown Jan. 14, 1914

20 UNDERTAKER ADDRESS

Charles H. Roby & Bro. Bel Air

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

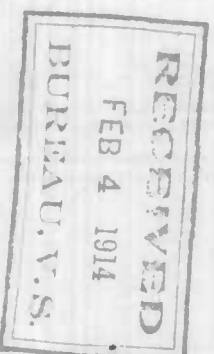
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Charles

488

167

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

104

Village or City

Rock Point

(No.)

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Joseph B. Johnson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Black

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

June

(Month)

(Day)

1912

(Year)

7 AGE

2

7

mos.

ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Woman

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Charles Co

10 NAME OF FATHER

John Johnson

11 BIRTHPLACE OF FATHER

(State or country)

Priginn

12 MAIDEN NAME OF MOTHER

Mary Ella Donley

13 BIRTHPLACE OF MOTHER

(State or country)

Charles Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John Johnson

(Address)

Rock Point

15

Filed

Jan 19

191

W. A. Meach

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan 17

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

191, to 191

that I last saw him alive on 191

and that death occurred on the date stated above, at 8 m.

The CAUSE OF DEATH* was as follows:

Acute burn - Clothing caught fire from stove.

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

N. H. Mandan, M.D.

(Address)

Temple Hill

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Church of the Holy Trinity

Jan 19, 191

20 UNDERTAKER

ADDRESS

J. C. Shy

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

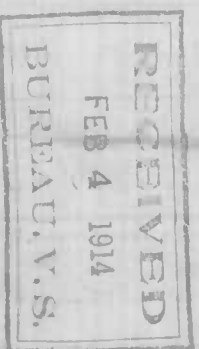
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory" (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

489

STATE OF MARYLAND
CERTIFICATE OF DEATHCounty CharlesRegistration Dist. No. 102Village or City La Plata (No. _____)

St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Susan Lancaster

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single
(Write the word)

6 DATE OF BIRTH Jan 1835 1836
(Month) (Day) (Year)

7 AGE about 75 yrs 1836
t LESS than
t day, hrs.
yrs. mos. ds. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work housework
(b) General nature of industry, business, or establishment in which employed (or employer) housework

9 BIRTHPLACE (State or country) Charles Co., Md

10 NAME OF FATHER James Lancaster
11 BIRTHPLACE OF FATHER (State or country) Charles Co., Md
12 MAIDEN NAME OF MOTHER Susan Lancaster
13 BIRTHPLACE OF MOTHER (State or country) Charles Co., Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Lancaster
(Address) La Plata, Md.

15 Filed Jan 4, 1914 R. Hampton Cox
Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 1st, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 24th, 1913, to Jan 1st, 1914.

that I last saw him alive on Jan 1st, 1914.

and that death occurred on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Hypertrophy with Dilatation

Contributory _____
Secondary _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Thos S Owen, M. D.

Jan 2nd, 1914. (Address) La Plata, Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Mt Rest Cem. La Plata DATE OF BURIAL Jan 4, 1914

20 UNDERTAKER Wm R. Clarke ADDRESS La Plata

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

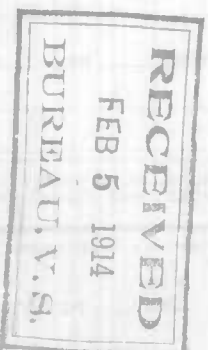
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tubercles of lungs, meninges, peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

490

County Chas.STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 100Village or City Spring Hill (No.)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Agnes Lloyd

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married
(Write the word)

6 DATE OF BIRTH March 17, 1892
(Month) (Day) (Year)

7 AGE 21 yrs. 10 mos. — ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) State Md.

10 NAME OF FATHER Geo. W. Hawkins

11 BIRTHPLACE OF FATHER (State or country) State Md.

12 MAIDEN NAME OF MOTHER Katherine Queen

13 BIRTHPLACE OF MOTHER (State or country) State Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo. W. Hawkins

(Address) Spring Hill,

15 Filed Jan 15, 1914 R. Hampton Cox
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. 14, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan. 12, 1914, to Jan 14, 1914, that I last saw him alive on " 13, 1914

and that death occurred on the date stated above, at 8:45 P.

The CAUSE OF DEATH* was as follows:

Mitral Regeneration with cardiac dilatation
(Duration) 0 yrs. 4 mos. — ds.

Contributory
Secondary

(Duration) yrs. mos. ds.
(Signed) Jas. J. Edelen, M. D.
Jan 15, 1914 (Address) La Plata,

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL New Town, Md. DATE OF BURIAL Jan 16, 1914

20 UNDERTAKER Mollie Roby ADDRESS Bel Air

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

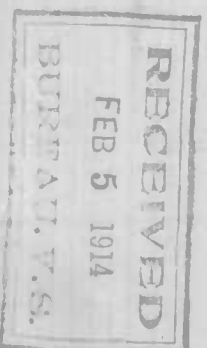
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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PLACE OF DEATH 1022.

County CharlesVillage or City Nanjemoy (No.)Registration Dist. No. 102

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

FULL NAME William Lyon

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDDED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH

(Month) (Day) (Year)

7 AGE

17 yrs. mos. ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

10 NAME OF FATHER

PARENTS

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed Mar 10, 1914

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

January 2nd, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

....., 191....., to....., 191.....

that I last saw h..... alive on....., 191.....

and that death occurred on the date stated above, at..... m.

The CAUSE OF DEATH* was as follows:

Accidental Drowning
(Verdict of Inquest)
(Found on shore of Potomac River
Between Smith Pt + Maryland Pt)

Contributory
Secondary

Acting Coroner (Duration) yrs. mos. ds.
(Signed) William E. Thompson D.O.

Mar 10th, 1914 (Address) Doncaster Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
If not at place of death?

Former or
usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Potomac River shore
Between Smith Pt + Md Pt Mar 10, 1914

20 UNDERTAKER

ADDRESS

Wm B Thompson Doncaster Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tetania," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

2743

189

County CharlesVillage or City Baltimore (No. _____, _____)

St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 1022 FULL NAME unknown

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

white5 SINGLE,
MARRIED,
WIDOWED,
ORDIVORCED
(Write the word)

6 DATE OF BIRTH

unknown, 1 _____
(Month) (Day) (Year)

7 AGE

unknownIf LESS than
1 day, _____ hrs.
_____ yrs. _____ mos. _____ ds. OR _____ min. ?

8 OCCUPATION

(a) Trade, profession, or
particular kind of workunknown(b) General nature of industry,
business, or establishment in
which employed (or employer)9 BIRTHPLACE
(State or country)unknown

PARENTS

10 NAME OF
FATHERunknown11 BIRTHPLACE
OF FATHER
(State or country)unknown12 MAIDEN NAME
OF MOTHERunknown13 BIRTHPLACE
OF MOTHER
(State or country)unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Francis E. Cunningham

(Address)

San Carlos Maryland

15

Filed

Mar 10 1914

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

unknown, 191____
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

_____, 191____, to _____, 191____.

that I last saw him _____ alive on _____, 191____.

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Cerebral
insufficiency resulting from
cause unknown.

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Francis E. Cunningham, M.D._____, 191____ (Address) San Carlos, Maryland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,
If not at place of death?Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

on River shore on farm
Brown as of Edward March 10 1914

20 UNDERTAKER

ADDRESS

William B. Thompson Danville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

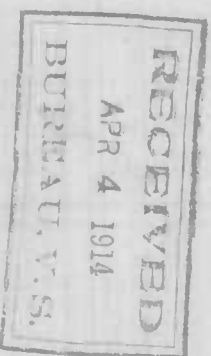
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Miscas* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-fenial," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

491

County

Charles

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 102

Village or City

Doncaster

(No.

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Otha Harrold Maddox

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED
(Write the word)

6 DATE OF BIRTH

Jan 16, 1914
(Month) (Day) (Year)

7 AGE

15 yrs. 15 mos. 15 ds. OR 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Chas Co Ind

10 NAME OF FATHER

Earnest Webster Maddox

11 BIRTHPLACE OF FATHER

(State or country)

Chas Co Ind

12 MAIDEN NAME OF MOTHER

Viola Maggie Pary

13 BIRTHPLACE OF MOTHER

(State or country)

Chas Co Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Earnest Webster Maddox

(Address)

Doncaster Ind

15

Filed

Jan 31, 1914

REGISTRAR

William B Thompson

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Apr 31, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

1914, to 1914,

that I last saw him alive on 1914,

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

in proper good battle
No violence or injuries
(Duration) yrs. mos. ds.

Contributory

Secondary

(Duration) yrs. mos. ds.

(Signed)

William B Thompson, M.D.

Jan 31, 1914 (Address) Doncaster Ind

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wanferney Church Feb 1, 1914

20 UNDERTAKER

ADDRESS

William B Thompson Doncaster Ind

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

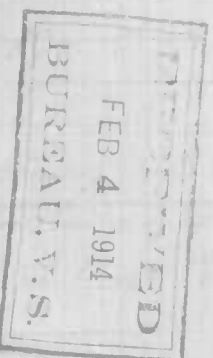
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH <i>Charles</i>		492		STATE OF MARYLAND CERTIFICATE OF DEATH	
County		82		Registration Dist. No. 102	
Village or City <i>Louisa</i>		(No.		St.; Ward)	
2 FULL NAME <i>Mollie Montgomery</i>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <i>Female</i>	4 COLOR OR RACE <i>Colored</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <i>Married</i> (Write the word)			
6 DATE OF BIRTH <i>Unknown, 1840</i> (Month) (Day) (Year)					
7 AGE <i>73</i> yrs. — mos. — ds. OR LESS than 1 day, — hrs. OR — min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work <i>At home.</i> (b) General nature of industry, business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <i>Unknown</i>					
PARENTS	10 NAME OF FATHER <i>Unknown</i>				
	11 BIRTHPLACE OF FATHER (State or country) <i>Unknown</i>				
	12 MAIDEN NAME OF MOTHER <i>Unknown</i>				
13 BIRTHPLACE OF MOTHER (State or country) <i>Unknown</i>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE Informant: <i>Robert Hancock</i> (Address): <i>Cross Roads Md 73</i>					
15 Filed <i>Jan 2</i> , 1914 <i>William B Thompson</i> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <i>Jan 1</i> , 1914 (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <i>Nov</i> , 1913, to <i>Nov 26</i> , 1913					
that I last saw her alive on <i>Nov 26</i> , 1913					
and that death occurred on the date stated above, at <i>8 P</i> m.					
THE CAUSE OF DEATH* was as follows: <i>Infirmities of Age,</i> <i>Cerebral Thrombosis</i> (Duration) — yrs. — mos. — ds. <i>Contributory Paralysis</i> (Secondary) (Duration) <i>4</i> yrs. <i>6</i> mos. <i>ds.</i>					
(Signed) <i>R. O. Bicknell</i> , M. D. <i>Jan 2</i> , 1913 (Address) <i>Pegah Md</i>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds. Where was disease contracted, If not at place of death? Former or usual residence.					
19 PLACE OF BURIAL OR REMOVAL <i>Int Hope Church</i>				DATE OF BURIAL <i>Jan 3</i> , 1914	
20 UNDERTAKER <i>William B Thompson</i>				ADDRESS <i>Doneast Md</i>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

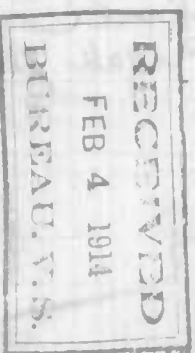
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1 PLACE OF DEATH

493

County CharlesVillage or City La Plata (No. 10)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 100

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Emma Henry

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH not known, 1846
(Month) (Day) (Year)

7 AGE 68 yrs. 0 mos. 0 ds. 11 LESS than 1 day. 0 hrs. OR 0 min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) —

9 BIRTHPLACE (State or country) Charles County

10 NAME OF FATHER Wilson Tucker

11 BIRTHPLACE OF FATHER (State or country) Chas Co

12 MAIDEN NAME OF MOTHER Ann Ruby

13 BIRTHPLACE OF MOTHER (State or country) Chas Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Emanuel Roberts

(Address) Hughesville

15 Jan 5th, 1914 R. R. Humphreys
Filed REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1914, to Jan 4, 1914, that I last saw her alive on Jan 1, 1914

and that death occurred on the date stated above, at noon m.
The CAUSE OF DEATH* was as follows:

Heart Failure

(Duration) 1 min. yrs. 0 mos. 0 ds.

Contributory (Secondary) Bronchitis
(Duration) 5 yrs. 0 mos. 16 ds.

(Signed) E. J. Stewart, M. D.
Jan 5, 1914 (Address) Blairstown

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, If not at place of death?
Former or usual residence —

19 PLACE OF BURIAL OR REMOVAL Grey Chapel, Md. DATE OF BURIAL Jan 6, 1914

20 UNDERTAKER Wm. R. Clarke ADDRESS La Plata

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

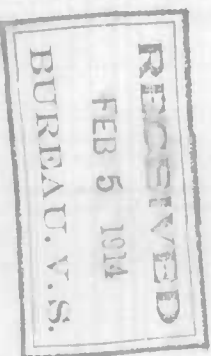
Approved by U. S. Census and American Public Health Association.¹

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

494

County ChasVillage or City Pomonkey (No. 189)Registration Dist. No. 106

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Arthur Shawe

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married
(Write the word)

6 DATE OF BIRTH Dec 16, 1836
(Month) (Day) (Year)

7 AGE 78 yrs. — mos. — ds. If LESS than 1 day, — hrs. OR — min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) England

PARENTS
10 NAME OF FATHER John Shawe
11 BIRTHPLACE OF FATHER (State or country) Scotlon
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Am Arthur Shawe(Address) Pomonkey

15 Filed Jan 12, 1914 John P. Marshall
Local REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 15, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from ———, 191——, to ———, 191——,

that I last saw h ——— alive on ———, 191——

and that death occurred on the date stated above, at ——— m.

The CAUSE OF DEATH* was as follows:

Heart failure

(Duration) ——— yrs. ——— mos. ——— ds.

Contributory (Secondary) ———

(Signed) John P. Marshall 2 Regt
Jan 12, 1914. (Address) Pomonkey

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ——— yrs. ——— mos. ——— ds. In the State ——— yrs. ——— mos. ——— ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Inf. Owl Camp Bldg DATE OF BURIAL Jan 12, 1914

20 UNDERTAKER W. R. Clark ADDRESS La Plala Rd

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

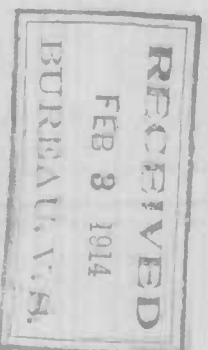
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—eccident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

495

STATE OF MARYLAND
CERTIFICATE OF DEATHCounty CharlesRegistration Dist. No. 100Village or City Port Tobacco (No. _____, _____)

St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Joseph Small

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH not known, 1861
(Month) (Day) (Year)

7 AGE about 53 yrs. — mos. — ds. IT LESS than 1 day, _____ hrs. OR, _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Labour
(b) General nature of industry, business, or establishment in which employed (or employer) day labour

9 BIRTHPLACE (State or country) Charles Co., Md

10 NAME OF FATHER Richard Small

11 BIRTHPLACE OF FATHER (State or country) Charles Co Md

12 MAIDEN NAME OF MOTHER Catharine Small

13 BIRTHPLACE OF MOTHER (State or country) Charles Co, Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Richard Small(Address) 2116-13th N. W Washington D. C.

15 Filed July 17, 1914 Geo. A. Wade Jr.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 12, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1913, to Jan 10, 1914,
that I last saw him alive on Jan 10, 1914.

and that death occurred on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage -
Paralysis
2nd attack
(Duration) about 1 yrs. mos. ds.

Contributory
Secondary

(Duration) _____ yrs. mos. ds.
(Signed) Thos. S. Owen, M. D.
Jan 17, 1914 (Address) La Plata Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted; If not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL W. Hill Port Tobacco DATE OF BURIAL Jan 18, 1914

20 UNDERTAKER Chas W. Roby & Co. ADDRESS Port Tobacco

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

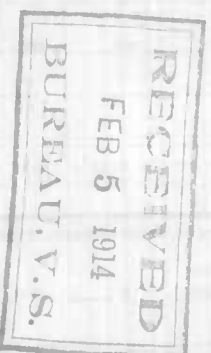
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

496

County Chas.STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 100Village or City Pomfret (No. 40 St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME James Edward Swann

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married
(Write the word)

6 DATE OF BIRTH Sept. 2, 1852
(Month) (Day) (Year)

7 AGE 61 yrs. — mos. — ds. OR LESS than 1 day, — hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Famer
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) md.

PARENTS
10 NAME OF FATHER Warren Swann
11 BIRTHPLACE OF FATHER (State or country) md.
12 MAIDEN NAME OF MOTHER Olivia Wright
13 BIRTHPLACE OF MOTHER (State or country) md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas E. Swann
(Address) Pomfret, Md.

15 Filed Jan 4, 1914 R. Hampton Cox REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan. 4, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May, 1913, to Jan. 4, 1914, that I last saw him alive on Dec. 29, 1913.

and that death occurred on the date stated above, at 9:45 A.M.

The CAUSE OF DEATH* was as follows:
Cancer of Stomach
+ Chronic nephritis
(Duration) — yrs. 9 mos. — ds.

Contributory — Secondary —
(Duration) — yrs. — mos. — ds.

(Signed) Joseph Edelstein, M. D.
Jan. 4, 1914 (Address) La Plata

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.
Where was disease contracted, It not at place of death?
Former or usual residence —

19 PLACE OF BURIAL OR REMOVAL Catholic Mt. Cem. Md. DATE OF BURIAL Dec 7, 1914
20 UNDERTAKER Wm R. Clarke ADDRESS La Plata

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

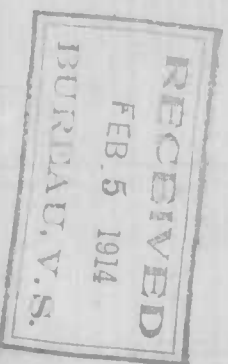
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonacum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), *23 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Charles</u> 497 10		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Rock Point</u> (No. <u>10</u>)		Registration Dist. No. <u>104</u>	
2 FULL NAME <u>John Thomas</u>		[It death occurred to a hospital or institution, give its NAME instead of street and number.]	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Male</u>	4 COLOR OR RACE <u>Black</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>	
6 DATE OF BIRTH <u>Jan 29</u> , 1887 (Month) (Day) (Year)			
7 AGE <u>27</u> yrs. mos. ds.		It LESS than 1 day, hrs. OR min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>of stonemason</u> (b) General nature of industry, business, or establishment in which employed (or employer)			
9 BIRTHPLACE (State or country) <u>Charles Co</u>			
PARENTS	10 NAME OF FATHER <u>Richard Thomas</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Charles Co</u>		
	12 MAIDEN NAME OF MOTHER <u>Lou Banks</u>		
13 BIRTHPLACE OF MOTHER (State or country) <u>Charles</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Willie Hansen</u> (Address) <u>Rock Point</u>			
15 Filed <u>Jan 30</u> , 1914 <u>W. A. Tule</u> <u>Dist. Local</u> REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>Jan 30</u> , 1914 (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from <u>Jan 30</u> , 1914, to <u>Jan 30</u> , 1914, that I last saw him alive on <u>Jan 30</u> , 1914, and that death occurred on the date stated above, at <u>7:30 A.</u> m, The CAUSE OF DEATH* was as follows: <u>Convulsion</u> (Duration) yrs. mos. ds. Contributory Secondary (Duration) yrs. mos. ds. (Signed) <u>N. H. Manlango, M.D.</u> <u>Jan 31</u> , 1914 (Address) <u>Expt. H. B. Hill</u>			
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence			
19 PLACE OF BURIAL OR REMOVAL or <u>The Land of G. H. Butler Jr</u>		DATE OF BURIAL <u>Jan 30</u> , 1914	
20 UNDERTAKER <u>C. C. Slye</u>		ADDRESS <u>Loson</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tubercles of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Malaria* (disease causing death), 23 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

FEB 4 1914

BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Charles 498

Village or City

Pomonkey (No.

2 FULL NAME

Jane Loyer

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 106

St.; Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE col. 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single (Write the word)

6 DATE OF BIRTH

April 10, 1890 (Month) (Day) (Year)

7 AGE

24 yrs. — mos. — ds. If LESS than 1 day, — hrs. OR — min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

General house work

(b) General nature of industry, business, or establishment in which employed (or employee)

Domestic

9 BIRTHPLACE (State or country)

Pomonkey, Ind.

10 NAME OF FATHER

Wm. Alexandria

11 BIRTHPLACE OF FATHER (State or country)

Chas Co Ind

12 MAIDEN NAME OF MOTHER

Mary Martin

13 BIRTHPLACE OF MOTHER (State or country)

Chas Co Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Robert Loyer

(Address)

Pomonkey, Ind

15

Filed

Jan 16, 1914 John P. Marchal REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

January 13, 1914 (Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

23-12-1913 to 13 Jan. 1914

that I last saw her alive on 30 Dec. 1913

and that death occurred on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis (?)

Duration — yrs. — mos. — ds. Contributory (Secondary) Pregnancy

(Signed)

E. M. Rye, M. D.

15 Jan. 1914 (Address) Pomonkey, Ind.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pomonkey Jan 16, 1914

20 UNDERTAKER

ADDRESS

John P. Marchal Pomonkey

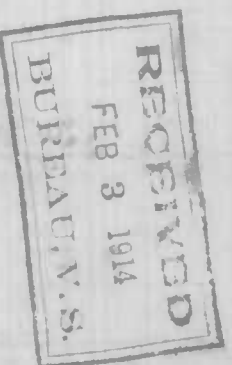
REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of _____ (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 da.*; *Bronchopneumonia* (secondary), *10 da.* Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicaemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be sketched under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

499

County

Charles Co.

Village or City

Spring Hill P. Office

(No.)

St.

Ward)

Registration Dist. No.

100

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Wilson Wallis

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

colored

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

married

6 DATE OF BIRTH

about

1840

(Month)

(Day)

(Year)

7 AGE

about

73 or 74

yrs.

mos.

ds.

If LESS than 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

Day Laborer

9 BIRTHPLACE

(State or country)

Charles Co., Ind.

10 NAME OF FATHER

Basil Wallis

11 BIRTHPLACE OF FATHER (State or country)

Charles Co., Ind.

12 MAIDEN NAME OF MOTHER

Margaret Wallis

13 BIRTHPLACE OF MOTHER (State or country)

Charles Co. Ind.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. Wallis

(Address)

La Plata Ind.

15

Filed

1914

R. H. Hackett, Cor.

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Jan

31

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Jan 25

1914

to

Jan 30

1914

that I last saw him alive on Jan 30, 1914

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

La Grippe, gastro-intestinal illness

(Duration)

about

yrs.

mos.

ds.

Contributory
Secondary

(Duration)

yrs.

mos.

ds.

(Signed)

Thos. J. Owen

M. D.

Feb 15

1914

(Address)

La Plata Ind.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

New Lawn Ind.

Feb 2, 1914

20 UNDERTAKER

ADDRESS

Simay & Penn

La Plata

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

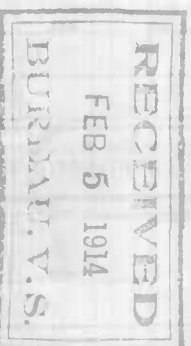
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH

500

County CharlesVillage or City Mar La Plata (No. _____)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 100

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Louise Watts

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single
(Write the word)

6 DATE OF BIRTH May 20th, 1898
(Month) (Day) (Year)

7 AGE 15 yrs. 7 moa. 21 ds. 11 LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) none

9 BIRTHPLACE (State or country) Charles Co., Md

10 NAME OF FATHER Matthew Watts

11 BIRTHPLACE OF FATHER (State or country) Charles Co., Md

12 MAIDEN NAME OF MOTHER Lina Lancaster

13 BIRTHPLACE OF MOTHER (State or country) Charles Co., Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thos. Chapman(Address) La Plata, Md

15 Filed Jan 11, 1914 R Hampton Cox
Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Jan 10th, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 8th, 1914, to Jan 8th, 1914, that I last saw him alive on Jan 8th, 1914

and that death occurred on the date stated above, at 12 m.
The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs
(Duration) 1 yrs. ____ mos. ____ ds.

Contributory
Secondary

(Duration) ____ yrs. ____ moa. ____ ds.
(Signed) Thos. S. Owen, M. D.
Jan 11, 1914 (Address) La Plata, Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ____ yrs. ____ moa. ____ da. In the State ____ yrs. ____ mos. ____ da

Where was disease contracted,
If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Mt Rest Ceme La Plata DATE OF BURIAL Jan 12, 1914

20 UNDERTAKER Wm A. Clarke ADDRESS La Plata

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

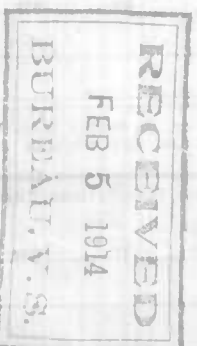
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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH

County

Charles

501

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registered No. 102

Village or City

Pisgah

(No.

St;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Thomas West

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

Colored

5 SINGLE,
MARRIED,
WIDOWED,
ORDIVORCED
(Write the word)

widowed

6 DATE OF BIRTH

Unknown Unknown, 1844
(Month) (Day) (Year)

7 AGE

70

yrs. in mos. unknowns.

If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

Farming

9 BIRTHPLACE
(State or country)

Virginia

10 NAME OF FATHER

Isaac West

11 BIRTHPLACE OF FATHER
(State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Singer West

13 BIRTHPLACE OF MOTHER
(State or country)

Abbeville, Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George Smith

(Address)

Westmoreland Co. Va.

15

Filed

Jan 7, 1914

William B. Thompson REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

January 25, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

Nov 1913, to Dec 1913

that I last saw him alive on Dec 27, 1913

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Apoplexy
from nephritis Chronic
213

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

G. C. Bicknell

M. D.

Jan. 6, 1914. (Address) Pisgah Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State 7 mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Mt. Hope Church Md.

Jan. 7, 1914

20 UNDERTAKER

ADDRESS

C. D. Carpenter

Jan. 7, 1914

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

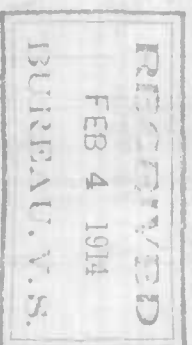
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer." "Foreman." "Manager." "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not fully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is inadequate); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of ----- (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-theia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tremor," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as accidental, suicidal, or homicidal, or as probably such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Charles

502

Village or City

Lassus

(No.

St.; Ward)

Registration Dist. No.

104

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Harry Wilson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

Black

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

single

6 DATE OF BIRTH

Jan 17

(Month)

(Day)

1914
(Year)

7 AGE

yrs. mos. ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

none

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Charles Co

PARENTS

10 NAME OF FATHER

Thomas G Wilson

11 BIRTHPLACE OF FATHER (State or country)

St Marys Co

12 MAIDEN NAME OF MOTHER

Nathie J Dyson

13 BIRTHPLACE OF MOTHER (State or country)

Charles Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Thomas G Wilson

(Address)

Lassus

15

Filed

Jan 8

1914

W.A. Male
Dist. Sec.

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*Jan 17**1914*
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on

and that death occurred on the date stated above, at *9 P. m.*

The CAUSE OF DEATH* was as follows:

burn before time

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

W. H. Mandanovich, M.D.
1914 (Address) *104*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

*Cottick Catholic Cemetery**Jan 18*, 1914

20 UNDERTAKER

ADDRESS

*Thomas Wilson**Lassus*

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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